No. 90-8466

IN THE
Supreme Court of the United States
OCTOBER TERM, 1991

DAVID E. RIGGINS,
Petitioner,

v.

STATE OF NEVADA,
Respondent.

On Writ of Certiorari to the Supreme Court of Nevada

BRIEF AMICUS CURIAE OF THE AMERICAN PSYCHIATRIC ASSOCIATION SUPPORTING PETITIONER

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

TABLE OF AUTHORITIES—Continued

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INTEREST OF AMICUS CURIAE

The American Psychiatric Association (APA), with approximately 40,000 members, is the nation's leading organization of physicians specializing in psychiatry. The APA has participated as *amicus curiae* in numerous cases involving mental health issues, including *Washington v. Harper*, 110 S. Ct. 1028 (1990), *Allen v. Illinois*, 478 U.S. 364 (1986), *Ake v. Oklahoma*, 470 U.S. 68 (1985), *Barefoot v. Estelle*, 463 U.S. 880 (1983), *Youngberg v. Romeo*, 457 U.S. 307 (1982), *Estelle v. Smith*,

451 U.S. 454 (1981), *Parham v. J.R.*, 442 U.S. 584 (1979), *Addington v. Texas*, 441 U.S. 418 (1979), and *O'Connor v. Donaldson*, 442 U.S. 563 (1975). The APA and its members have substantial expertise on the uses and effects of antipsychotic medication. We believe that this expertise will be useful to the Court in its consideration of this case, which concerns the involuntary administration of antipsychotic medication to a criminal defendant asserting the insanity defense.[1]

STATEMENT

Petitioner David E. Riggins was charged in Nevada state court with first degree murder and robbery with use of a deadly weapon. He pleaded not guilty and not guilty by reason of insanity. After being found competent to stand trial, he was tried in November 1988. Riggins testified at his trial. He was convicted on both charges and sentenced to death.

Riggins was arrested the day of the murder, in November 1987. Within a week, a psychiatrist provided by the State, Dr. Quass, placed Riggins on Mellaril, an antipsychotic drug, with Riggins' consent. *Riggins v. State*, 808 P.2d 535, 537 (Nev. 1991); Record on Appeal (R.O.A.) 448, 740. Riggins complained of hearing voices and of having difficulty sleeping, and he said that he had taken the medication previously. R.O.A. 440-41. He also stated that he was not on any prescription medication on the morning of the killing and robbery. R.O.A. 740. His dose originally was low, 100 mg per day. R.O.A. 448.

In January 1988, the trial court ordered Riggins examined to determine his competence to stand trial. R.O.A. 25. Three psychiatrists examined him (*see* R.O.A. 77); one concluded (first in February, again in June) that Riggins was not competent to stand trial (and was insane at the time of the offenses). R.O.A. 78, 93-96. In March 1988, based on the examinations, the court found that Riggins was competent. R.O.A. 31-32. By the time of the competence determination, Riggins' original dose of 100 mg of Mellaril per day had been increased to 450 mg per day. 808 P.2d at 537; R.O.A. 441.

[1] Letters from the parties giving consent to the filing of this brief have been filed with the Clerk of the Court.

In June 1988, at the same time that he gave notice of an insanity defense, Riggins moved to terminate administration of the Mellaril. R.O.A. 52-56. He argued that continuing the medication during trial would violate his right to display his demeanor to the jury unaffected by the State (R.O.A. 54) and his "right to offer to the jury his demeanor in a state similar to th[e] one he was in at the time of the alleged offense." R.O.A. 103; *see id.* at 52-56, 100-07. He also stated that he "has done nothing to indicate that his presence, unfettered by Mellaril will in any way interfere with the State of Nevada's legitimate interest in an orderly trial." R.O.A. 56. The State opposed the motion, contending based on the psychiatric reports submitted for the competence determination that the medication was necessary to maintain Riggins' competence to stand trial. R.O.A. 79-80; *id.* at 74-87. The court held a hearing in July 1988, at which a number of psychiatrists testified. R.O.A. 401-505. The trial court denied the motion, without making any specific findings as to the need for the medication. R.O.A. 108. By the time of the hearing, and his trial in November 1988, Riggins was being medicated with 800 mg of Mellaril per day. 808 P.2d at 537; R.O.A. 415.

On appeal from his conviction, Riggins challenged the forced medication during trial. According to the Nevada Supreme Court, Riggins' principal, if not sole, argument was that involuntary medication with antipsychotic drugs during the trial deprived him of his right to present his natural demeanor to the jury as part of his insanity defense. *See* 808 P.2d at 537. The Nevada Supreme Court rejected the challenge.

The court noted, and seemingly accepted, the view of other courts addressing the issue that "the accused's demeanor has probative value where his sanity is in issue." *Ibid.* The court concluded, however, that "there was ample expert testimony regarding the effect that the Mellaril had on Riggins" and that such "expert testimony was sufficient to inform the jury of the effect of Mellaril on Riggins' demeanor and testimony." *Id.* at 538. Because of this adequate substitute for demeanor evidence, the court held that the involuntary medication did not deprive Riggins "of his rights to a full and fair trial and to present a defense." *Ibid.* In reaching that conclusion, the court nowhere examined whether the medication was needed to maintain Riggins' competence or whether the State otherwise had a sufficient justification for administering the medication.[2]

SUMMARY OF ARGUMENT

Antipsychotic medication is an accepted, beneficial, and often essential treatment for many patients suffering from psychotic disorders. In particular, such medication may be the only reasonable means of treating a defendant in custody who is mentally ill and dangerous to himself or others. *See Washington v. Harper*, 110 S. Ct. 1028 (1990). Such medication may also be the only reasonable means of restoring or maintaining a defendant's competence to stand trial.

Antipsychotic medication may be misused, however, and may have side-effects. Some of these side-effects may adversely affect a jury's impression of a medicated defendant at trial. Those potential consequences of antipsychotic medication are enough to give a defendant like

[2] The concurring opinion by Justice Rose stressed that the record was sparse on that issue. 808 P.2d at 539 (Rose, J., concurring). One justice dissented on the broad ground that "[a]n accused has a right to be present at the trial in a natural state, free from the effects of modern mind meddling." *Id.* at 542 (Springer, J., dissenting).

petitioner a cognizable due process interest that is sufficient to demand that the State have an overriding interest in order to medicate a defendant against his will.

Although that conclusion applies to all cases, demeanor evidence might be particularly influential in cases where an insanity defense is at issue. Demeanor might also be particularly influential in a capital sentencing proceeding, where the jury is called on to make a moral, and not purely factual, judgment. This case involves both circumstances. On the other hand, nothing significant is added to the analysis by petitioner's claim of a distinct constitutional interest in displaying a "psychotic demeanor" to the jury in order to bolster his insanity defense. That claim not only is unnecessary to trigger a requirement that the State justify administering the medication but, even on its merits, seems at best too weak to alter the result of the due process balance.

In striking that balance, the Court must consider the two types of state interests that might justify involuntary medication of a criminal defendant: the State's interest in restoring or maintaining the defendant's competence to stand trial; and the State's interest in treating the mental illnesses of persons in the institutional care of the State, as in *Harper*. Both of those interests are important, but only this Court can strike the balance of values that the due process analysis calls for. If the state interests are held sufficient to justify medication, however, they can be sufficient only if, in any particular case, medication is in fact necessary to serve those interests—to restore or maintain competence, or to meet the treatment needs of a defendant in custody. It is also important that both potential justifications require, as a precondition to medicating, that the medication be in the patient's medical interest and that the effects of medication be properly monitored throughout the criminal proceedings.

On the assumption that the State's *Harper* and competence interests could be sufficient if established, it is clear that the judgment below nevertheless cannot stand. The Nevada Supreme Court did not consider it necessary even to examine whether the State had justified the medication of Riggins. Moreover, there is no finding by the state trial court on either potential justification, and the record is hardly so clear as to compel any such finding and thereby make unnecessary any express findings on the issue. In these circumstances, this case at a minimum should be remanded for a determination whether any effects on petitioner at trial or at the sentencing were justified by a sufficient state interest.

ARGUMENT

THE NEVADA SUPREME COURT ERRED IN FAILING TO CONDUCT AN INQUIRY INTO, OR DEMAND SPECIFIC FINDINGS ON, WHETHER THE STATE HAD ANY OVERRIDING INTERESTS THAT JUSTIFIED CONTINUING THE ANTIPSYCHOTIC MEDICATION OF PETITIONER AGAINST HIS WISHES

A. The Uses and Effects of Antipsychotic Medication

The medication at issue in this case, Mellaril (the trade name for thioridazine), is one of a number of "antipsychotic" drugs, also called "neuroleptic" or "psychotropic" drugs. *See Washington v. Harper*, 110 S. Ct. 1028, 1032 & n.1 (1990). The category of antipsychotics differs from the other major categories of psychiatric medication, antidepressants and lithium. While the latter are used to treat potentially debilitating *mood* disorders, antipsychotics are used to treat serious disorders of the mind where reality cannot be distinguished from fantasy, manifested in hallucinations, delusions, and thought disorganization. *See* R. Baldessarini, *Chemotherapy in Psychiatry* chs. 2-4 (rev. ed. 1985). In particular, Mellaril is used to counter the effects of psychotic thought processes. *See* R.O.A. 407-08 (dose range of 300-800 mg per day); *American Psychiatric Press Textbook of Psychiatry* 771 (J. Talbott, R. Hales, & S. Yodofsky eds., 1988) (hereafter *Textbook of Psychiatry*) (dose range of 200-600 mg per day).

Psychotropic medication such as Mellaril is widely accepted within the psychiatric community as a highly effective treatment—indeed, the treatment of choice—for large numbers of persons suffering from both acute and chronic psychoses, particularly schizophrenia. As indicated by the most recent comprehensive review of the treatment of schizophrenia published by the National Institute of Mental Health (NIMH), "[a]ntipsychotic [neuroleptic] drugs generally have a dramatic effect on the symptoms of schizophrenia (e.g., delusions, hallucinations, and thought disorder) within 4-6 weeks, although improvement may continue well after that interval." Kane, *Treatment of Schizophrenia*, 13 Schizophrenia Bull. 133, 142 (1987). The NIMH review pointed out that "[a]ntipsychotic (neuroleptic) drugs remain the primary modality in the treatment of an acute episode or an acute exacerbation of a schizophrenic illness." *Id.* at 134. The study also documented the value of antipsychotic medication for the long-term treatment of chronic psychosis: "Maintenance antipsychotic drug treatment has proved to be of enormous value in reducing the risk of psychotic relapse and rehospitalization." *Id.* at 143. The study concluded: "The available data do not support the feasibility of substituting any psychotherapeutic strategy for drug treatment on an indefinite basis." *Id.* at 142. *See generally Textbook of Psychiatry* 774.[3]

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[3] "[T]here is still no single substitute for neuroleptics for control of symptoms and prevention of relapse in the majority of chronic schizophrenic patients. Denying these patients the benefit of the neuroleptic action without offering any suitable alternative may be considered a clinical error." Jeste & Wyatt, *Changing Epidemiology of Tardive Dyskinesia: An Overview*, 138 Am. J. Psychiatry 297, 306 (1981) (footnote omitted). *See also* Kane, et al., *Clozapine for the Treatment-Resistant Schizophrenic*, 45 Archives Gen. Psychiatry 789 (1988).

Antipsychotic medication may reduce a psychotic patient's dangerousness to himself or others that stems from the disorder, including violence that might otherwise require physical restraints to be prevented or controlled. *See Harper*, 110 S. Ct. at 1039 & n.9. The medication, however, is not simply a pharmacological restraint. Rather, the direct effect is to clear the hallucinations and delusions that are produced by psychosis (and that may cause dangerous behavior). The medication is thus directly therapeutic, in both the short and long terms: it alleviates the present mental suffering; and it facilitates long-term stability and decreases the need for extended hospitalization. *See Textbook of Psychiatry* 770-74 (describing effects and citing sources).[4]

The actual effects of properly used antipsychotics on mental functioning belie the spectre of mind control through " 'chemical lobotomy' " raised by the dissent in the court below. *Riggins*, 808 P.2d at 540 (Springer, J., dissenting). There is simply no clinical basis for a concern that antipsychotics impinge on protected interests in speech or thought: to the contrary, antipsychotic medication, when properly used to treat the severely mentally ill, *furthers* traditional concerns for freedom of speech and thought by enhancing the patient's ability to concentrate, to read, to learn, and to communicate. According to one study of the clinical effects of antipsychotic medication on thought processes ("mentation"), "[t]he experimental data cannot be interpreted as being consistent with a view of these drugs as mind-altering, thought-inhibiting, or destructive of personality in a negative sense. In fact, the beneficial effects of the medication on

[4] *See also* Appelbaum & Gutheil, *Rotting With Their Rights On*, 7 Bull. Am. Acad. Psychiatry & L. 306, 308 (1979); Spohn, et al., *Phenothiazine Effects on Psychological and Psychophysiological Dysfunction in Chronic Schizophrenics*, 34 Archives Gen. Psychiatry 633 (1977). The decrease in distorted thinking increases a patient's potential for deriving long-term benefits from other, non-pharmacological treatment, such as psychotherapy or milieu therapy.

complex aspects of mentation suggest that the opposite conclusion is true: the medications reinforce the most important aspects of mental functioning." Gutheil & Appelbaum, *"Mind Control," "Synthetic Sanity," "Artificial Competence," and Genuine Confusion: Legally Relevant Effects of Antipsychotic Medication*, 12 Hofstra L. Rev. 77, 119 (1983).

Antipsychotic medication is thus a powerful tool for inducing (rather than impairing) competence. While it is possible to label the result "synthetic sanity" (*Riggins*, 808 P.2d at 540 (Springer, J., dissenting)), the label is misleading in its perjorative connotation suggesting condemnation of the drugs. The mental health produced by antipsychotic medication is no different from, no more inauthentic or alien to the patient than, the physical health produced by other medications, such as penicillin for pneumonia (which might be labeled "synthetic fitness" or "synthetic health"). By controlling psychotic symptoms, medication such as Mellaril is used to restore *normal* thought processes, allowing the "cognitive part of the brain to come back into play." *State v. Jojola*, 89 N.M. 489, 492, 553 P.2d 1296, 1299 (Ct. App. 1976). Accord *State v. Hayes*, 118 N.H. 458, 389 A.2d 1379 (1978); *State v. Law*, 270 S.C. 664, 244 S.E.2d 302 (1978).

To be sure, like any medication, psychotropic medication can be abused. Such medication can be misprescribed to patients for whom it is not medically indicated; and it can be prescribed in dosages exceeding what is medically indicated. But the risk that psychotropic drugs will be misprescribed—solely, for example, to oversedate or to tranquilize a patient, without therapeutic justification (*see Riggins*, 808 P.2d at 541 (Springer, J., dissenting)) —is hardly unique to this form of medication or calls for disregard of the medical benefits. It means only that medical judgment must be carefully exercised to ensure that such medication is given only when needed to treat psychotic symptoms.

Even when properly used, antipsychotic medication—again, like other medications—can cause unwanted side effects. This Court described some of them, including the particularly serious one of tardive dyskinesia, in *Harper*, 110 S. Ct. at 1041. Most of these side-effects, however, may be controlled by lowering dosages or by adding another medication; such side effects ordinarily cease when antipsychotics are discontinued. *See* R. Baldessarini, *supra*, at 70-71; APA, *Task Force Report 18: Tardive Dyskinesia* 13-19 (1980).[5]

Of particular relevance to this case, antipsychotic medication can cause a number of side-effects that are readily observable and therefore may affect a jury's view of a medicated defendant. Notably, the drugs may cause akathisia, a form of "motor restlessness, often characterized by an inability to sit still." *Harper*, 110 S. Ct. at 1041. They may also cause parkinsonism, characterized (like the naturally occurring Parkinson's disease) by a resting tremor of the limbs, diminished range of facial expression, or slowed movements and speech. And in extreme cases, the sedation-like effect may be severe enough

[5] Tardive dyskinesia is a condition characterized by involuntary tic-like movements, generally of the tongue, of facial or neck muscles, or of the extremities. R. Baldessarini, *supra*, at 75; *see Harper*, 110 S. Ct. at 1041. But even that side-effect occurs in only a distinct minority of patients (*Harper*, 110 S. Ct. at 1041; APA, *Task Force Report 18*, at 45), is not generally progressive even when the antipsychotics are continued after the condition develops (Kane, 13 Schizophrenia Bull. at 150), and often abates some time after medication is reduced or discontinued (Jeste & Wyatt, *In Search of Treatment for Tardive Dyskinesia: Review of the Literature*, 5 Schizophrenia Bull. 251, 269, 275 (1979); *see also* Jeste & Wyatt, *Therapeutic Strategies Against Tardive Dyskinesia*, 39 Archives Gen. Psychiatry 803, 812 (1982); Yagi & Itoh, *Follow-Up Study of 11 Patients with Potentially Reversible Tardive Dyskinesia*, 44 Am. J. Psychiatry 1496, 1496, 1498 (1987)). *See Textbook of Psychiatry* 781-83. Proper medical monitoring can certainly reduce, if not arrest, the development of more serious forms of tardive dyskinesia. *See* APA, *Task Force Report 18*, at 137-53; Jus, et al., *Long-Term Treatment of Tardive Dyskinesia*, 40 J. Clinical Psychiatry 72, 75-77 (1979).

(akinesia) to affect thought processes. *See* Gutheil & Applebaum, 12 Hofstra L. Rev. at 107-08; *Textbook of Psychiatry* 777-80. There is, however, little reliable evidence that properly used antipsychotic medication has any significant adverse effect on attention or perception. Gutheil & Appelbaum, 12 Hofstra L. Rev. at 110-13. And it is well established that the foregoing side-effects are readily subject to reversal or control by adjusting doses or prescribing counteracting medication. *Id.* at 108; *Textbook of Psychiatry* 779-80.

B. The Due Process Balance

This Court's due process analysis calls for a balancing process, weighing "the individual's interest in liberty against the State's asserted reasons for restraining individual liberty." *Youngberg v. Romeo*, 457 U.S. 307, 320 (1982). The inquiry involves two steps: " 'a definition of th[e] protected constitutional interest, as well as identification of the conditions under which competing state interests might outweigh it.' " *Washington v. Harper*, 110 S. Ct. at 1036 (quoting *Mills v. Rogers*, 457 U.S. 291, 299 (1982) (citations omitted)). In the present context, a defendant like petitioner has a cognizable interest in avoiding compelled medication; and that interest, while not as broad as petitioner asserts, should be deemed sufficiently frought with the potential to affect the trial as to demand inquiry, in the criminal proceeding, into whether the State has an interest in medicating that outweighs the defendant's interest in cessation of the drug.[6]

1. *The Defendant's Interests*

a. Under the Court's ruling in *Washington v. Harper*, *supra*, a criminal defendant like petitioner undoubtedly has a constitutionally recognized liberty interest in avoid-

[6] We follow the due process analysis here. It is not clear why any different analysis would be called for under a Sixth Amendment right "to a full and fair trial." Pet. i. *Cf. Strickland v. Washington*, 466 U.S. 668, 684-85 (1984) (due process guarantees fair trial, but Sixth Amendment defines basic elements of fair trial).

ing the unwarranted administration of antipsychotic drugs. 110 S. Ct. at 1036-37; *id.* at 1041 ("[t]he forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty"). And because the interest rests not only on the initial administration but on the effect of the medication, the liberty interest naturally covers any excessive use of antipsychotic drugs as well. *See Jones v. United States*, 463 U.S. 354, 385 n.19 (1983) (Brennan, J., dissenting). This interest is sufficient to require state justification for the involuntary administration of psychtropic medication at the prescribed dose.

b. Although the basic constitutional liberty interest recognized in *Harper* requires state justification for involuntary medication, that requirement might in particular cases have nothing to do with the patient's status as a criminal defendant. Conceivably, there may be no prejudice to his case—his demeanor or his defense—resulting from the medication. The *Harper* liberty interest, standing alone, therefore might not be sufficient to give a criminal defendant a basis for raising the due process challenge to involuntary medication in the criminal proceeding (rather than, for example, in a collateral civil suit).

The potential side-effects of the medication, however, connect the issue to the trial process. As discussed above, antipsychotic drugs may have sedative effects, may cause restlessness, and may otherwise influence the defendant's demeanor while sitting at the defense table as well as his demeanor and mode of speech while testifying. The potential adverse impact on the defendant's case is sufficient to bring the due process clause into play in the criminal case.

As the Nevada Supreme Court recognized, a defendant's demeanor and appearance in the courtroom unquestionably may have an effect on the jury. Certainly if the defendant testifies, as Riggins did, his demeanor and the

manner in which he speaks may have a significant bearing on his persuasiveness. Indeed, jury instructions often explicitly inform juries that they may consider such aspects of testimony in assessing it. *See* 1 E. Devitt & C. Blackmar, *Federal Jury Practice and Instructions* § 17.01, at 519-20 (3d ed. 1977) (jury directed to consider "demeanor and manner while on the stand" in judging witness's credibility); R.O.A. 226 (jury instruction in this case). Even if the defendant does not testify, it is only common sense that the jurors are likely to be watching him and his reactions to testimony and other courtroom events, and allowing their judgment of the defendant's guilt, or appropriate sentence in a capital case, to be influenced by those reactions.[7]

By administering medication, the State may be creating a prejudical negative demeanor in the defendant—making him look nervous and restless, for example, or so calm or sedated as to appear bored, cold, unfeeling, and unresponsive. *See, e.g.*, R.O.A. 420, 430, 465. That such effects may be subtle does not make them any less real or potentially influential. Their significance may be enhanced in a case involving the insanity defense, in which the jury may be especially sensitive to the defendant's demeanor for what it may reflect about his future conduct if acquitted. Demeanor may likewise be of special significance in capital sentencing, in which the jury is properly called on to make a partly forward-looking, moral judgment about the defendant as a person, rather than engaging in purely retrospective factfinding. *See Penry v. Lynaugh*, 492 U.S. 302, 319, 323 (1989); *Jurek v. Texas*, 428 U.S. 262 (1976).

The basic guarantee of an adversary system in which the State has the burden of proving the defendant guilty with evidence at trial, and the defendant has a broad right to select his own evidence for his defense, demands

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[7] Witnesses themselves may be affected by the defendant's demeanor when "confronting" the defendant while they are testifying. *Cf. Coy v. Iowa*, 487 U.S. 1012 (1988).

that the State be required to justify any step that imposes such an evidentiary handicap on the defendant.[8] When the State forces the defendant to start with one strike against him for no legitimate reason, he is deprived of his constitutional right to demand that the government prove its case beyond a reasonable doubt, without assistance from the defendant. *See In re Winship*, 397 U.S. 358 (1970).[9] In short, compelling medication requires justification because it may tilt the balance of the adversary system against the accused.

It is doubtless true that expert witnesses can do much to explain the altered demeanor to a jury, as the Nevada Supreme Court concluded. *Riggins*, 808 P.2d at 537-38. And the ability to explain the effects of medication, and thus to mitigate the potential harm, is surely an important factor in weighing the sufficiency of the state justification.[10] But such explanations cannot be a certain

[8] Government influencing of the demeanor of any defense witness, including the defendant, implicates the defendant's right to " 'present his own witnesses to establish a defense.' " *Webb v. Texas*, 409 U.S. 95, 98 (1972) (quoting *Washington v. Texas*, 388 U.S. 14, 19 (1967)).

[9] Such a step may be analogized to, though is obviously less intrinsically prejudicial than, forcing a defendant to wear prison clothes (*Estelle v. Williams*, 425 U.S. 501 (1976)) or shackling and gagging a defendant (*Illinois v. Allen*, 397 U.S. 337 (1970)). *See also Holbrook v. Flynn*, 475 U.S. 560, 567-68 (1986); *Taylor v. Kentucky*, 436 U.S. 478, 485 (1978). In the due process balance, of course, the ease, or even possibility, of a state justification must vary with the potential for prejudice.

[10] The American Bar Association's Criminal Justice Mental Health Standard 7-4.14, in affirming the sufficiency of the state interest in medicating a defendant to restore or maintain his competence to stand trial, recognizes the importance of explanatory evidence, in subsection (b): "[i]f the defendant proceeds to trial with the aid of treatment or habilitation which may affect demeanor, either party should have the right to introduce evidence regarding the treatment or habilitation and its effects and the jury should be instructed accordingly."

and perfect cure for the subtle harms the defendant may suffer. And as long as the risks of prejudice are real, as they unavoidably are, a State should not be left entirely free to meddle with the defendant's demeanor, and thus help its own case, without having to offer any justification for doing so. That such an impairment of the adversary system may prove ultimately harmless, which it is by no means certain to do, does not render it any less an impairment.

Indeed, due process should be held to demand a state justification for compelled medication of a criminal defendant in every case where the defendant raises the issue, without requiring a case-by-case threshold demonstration by the defendant that the particular medication had, or would have, an adverse effect on the defendant's demeanor in the eyes of the jury. For one thing, the question of medication must be addressed before the trial, so any effect on jurors would be a matter, not of observation, but of uncertain prediction. Moreover, such effects are likely to be subtle and hard to identify objectively. At the same time, such subtle effects might be influential: demeanor may be a significant, if hard to articulate, factor in a jury's consideration of the defendant's guilt. And from the State's point of view, it is hard to see why the State should *not* have to offer a justification for compelled medication when challenged, as long as the practical burden of such a requirement is not onerous—which it should not be if, as seems proper, the testimony of the prescribing psychiatrist will suffice.[11] For those reasons, a clear general rule requiring such a

[11] Of course, the issue will not be raised in many cases because there will be no serious dispute about the need for medication. Moreover, it is to be expected that the matter often will be fully disposed of in a hearing on the defendant's competence to stand trial. It would be proper for a trial court to require some indication of a material dispute before conducting a separate hearing on the subject. And there may be no reason why, in many cases, the entire matter should not be handled through written submissions.

state justification is warranted. *See Mathews v. Eldridge*, 424 U.S. 319 (1976) (procedural due process test).[12]

c. In this Court and in the courts below, Riggins goes one step further and asserts that he has a distinct constitutionally protected interest in appearing before the jury as he appeared at the time of the alleged crime. Thus, beyond asserting the interest in not having the jury "misled by the demeanor of a defendant who appears not to care about the crime, the victim, or the proceedings or who appears overly anxious at particular moments," which we agree is protected, Riggins asserts a constitutional right to appear in his "natural" state so that the jury does not "get a false impression of the defendant's mental state at the time of the crime." Pet. 15. But this argument could not add anything to the already-established right to demand a state justification for administering medication unless this additional interest were deemed of such great weight that it outweighed a state interest that would otherwise be adequate to justify medication. The contention that this interest is so weighty as to alter the constitutional balance is untenable.

For one thing, the actual evidentiary significance of demeanor in persuading the jury of the defendant's insanity at the time of a crime is not particularly strong. An individual's psychotic state may not be evidenced in his or her appearance or demeanor. A person who appears calm may be no more or less sane—able " 'to distinguish right from wrong as to the particular act in question' " (*Williams v. State*, 85 Nev. 169, 173, 451 P.2d 848, 851 (1969)); R.O.A. 218 (jury instruction on insanity defense)—than an individual who exhibits anxious or active forms of behavior. *See, e.g.*, R.O.A. 419, 433. There is, quite simply, a weak evidentiary connection between demeanor and sanity.

[12] This is not to say that, on appeal, harmless error analysis would not be appropriate.

Moreover, with or without psychotropic medication, a defendant's demeanor and appearance in the courtroom may well be different from what it was at the time of the charged offense. The passage of time itself may alter demeanor. The formal courtroom setting, as well as the structured prison environment of a defendant in custody, may also alter the defendant's behavior and demeanor. Of course, these and other factors, including the medication, may be explained to the jury to help it understand why the defendant does not "appear psychotic." And psychiatric testimony and other evidence offer alternative —typically, more reliable—means by which the defendant may seek to prove his state of mind at the time of the offense.

Giving much weight to this interest would, in addition, create serious practical problems. If a defendant is taken off medication, he may not relapse into his psychotic state at all; a court would have to decide how long to wait before proceeding with the trial. On the other hand, the defendant may become incompetent to stand trial, necessitating potentially indefinite delays. *See, e.g.*, R.O.A. 418. The defendant may not return to his original psychotic state but develop quite different symptoms reflected in a quite different demeanor. And the defendant may, even if still competent, become unmanageable and require even more prejudicial restraints in the courtroom or require renewed medication to prevent dangerous behavior while in custody. There is no sufficient reason to impose on the courts these and perhaps other problems if the State has an otherwise sufficient justification for administering antipsychotic medication.[13]

[13] Beyond the defendant's interests discussed in text, a defendant, of course, has a right not to be rendered incompetent to stand trial—necessarily implied by his right not to *be* incompetent at trial. *See Drope v. Missouri*, 420 U.S. 162, 171-72 (1975). Abuse of psychotropic drugs, like abuse of almost any drug, could conceivably impair that right by interfering with a defendant's ability to understand the proceedings and to assist counsel. *See, e.g.*,

2. *The State's Interests*

The first of the two obvious state interests that might justify antipsychotic medication of a criminal defendant against his will is reflected in *Washington v. Harper*, *supra*. The Court there upheld such medication of prisoners when it was "in the prisoner's medical interests, given the legitimate needs of his institutional confinement" (110 S. Ct. at 1037)—in that case, when a psychiatric determination was made that the medication was appropriate treatment for the mental illness of a patient who was gravely disabled or dangerous to himself or others. *Id.* at 1035, 1039. The clinical decision to administer antipsychotic medication should take into account the patient's wishes, the implications of involuntary treatment, the risks of foregoing treatment for an individual who may prove violent, the individualized risk of side effects, and the relative risks and benefits of other potential treatments.[14] When made in that manner, the decision to medicate largely brings together the legitimate institutional interests of the State and the patient's interest in receiving appropriate treatment (itself a state interest, through the State's *parens patriae* power).[15] This state interest in treatment consistent with individual and institutional needs, of course, applies to all individuals in the State's institutional care, including a criminal defendant awaiting trial.

R.O.A. 420. But Riggins' counsel did not claim at or before Riggins' trial, and Riggins has not claimed here, that the administration of Mellaril rendered Riggins incompetent to stand trial. *See, e.g.*, R.O.A. 503.

[14] *See Rennie v. Klein*, 720 F.2d 266, 272 (3d Cir. 1983) (Adams, J., concurring); *id.* at 273-74 (Seitz, C.J., concurring); Appelbaum & Gutheil, *Clinical Aspects of Treatment Refusal*, 23 Comprehensive Psychiatry 560 (1982).

[15] *See Youngberg v. Romeo*, 457 U.S. 307, 321 (1982); *Addington v. Texas*, 441 U.S. 418, 426 (1979) ("state has a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable because of emotional disorders to care for themselves"); *O'Connor v. Donaldson*, 422 U.S. 563, 575 (1975).

The second state interest that might justify involuntary medication of a criminal defendant is the state interest in restoring or maintaining his competence to stand trial. A defendant who is suffering from severe psychoses may not be able to understand the criminal proceedings or assist in his defense. *See Drope v. Missouri*, 420 U.S. 162 (1975). The fact is that, given the dearth of comparably effective alternatives to antipsychotic medication, such a defendant may remain in that condition indefinitely if medication is not given. Allowing that result would impair strong state interests: the interest in *promptly* adjudicating a defendant's guilt (*see Flanagan v. United States*, 465 U.S. 259, 264-65 (1984)); the interest in *ever* adjudicating the case, for delay may result in the disappearance of crucial evidence and make a trial impossible (*see Barker v. Wingo*, 407 U.S. 514 (1972)); and the interest in not having to "warehouse" an unconvicted individual indefinitely, especially one who could be made competent through medication.

Whether these state interests outweigh the defendant's interests is ultimately a matter only this Court can decide. In striking the due process balance, however, the Court should recognize that the two state interests will often reinforce each other: treatment and institutional needs will often coincide with the need to restore or maintain competence. The Court must also consider whether the balance is different for trials and for capital sentencings, which involve different jury determinations that may be influenced differently by the effects of medication on a defendant's demeanor.

In general, though, on one side of the balance, the various state interests are obviously important ones. These include the state interest in avoiding either indefinite institutional confinement without appropriate care or the "revolving door" effect that might follow from recognizing any rigid right of a defendant to be unmedicated when tried—medicate to competence, for *Harper*-type reasons, while the defendant is in custody before trial; stop medication as the trial approaches; post-

pone the trial as the defendant becomes incompetent while off medication; resume medication to competence upon return to custody; then repeat the cycle. *See* ABA Criminal Justice Mental Health Standard 7-4.14 Commentary, at 253. On the other side of the balance, it is important to consider that monitoring and explaining the effects of medication can reduce the adverse impact on the defendant's criminal case and that, as explained above, the medication itself, properly used, has powerful medical benefits for the defendant. However the Court strikes the balance, it should remain a basic precondition to prescribing medication that the medication be appropriate treatment in the defendant's medical best interests, that there be appropriate monitoring and counteracting of any side-effects (particularly those which might affect jury opinions), and that the defendant be entitled to offer evidence explaining his demeanor to the jury. *See* ABA Criminal Justice Mental Health Standard 7-4.14 ("A defendant should not be considered incompetent to stand trial because the defendant's present mental competence is dependent upon continuation of treatment or habilitation which includes medication . . . .").[16]

C. The Record in This Case

Even if the State could justify involuntary medication on the grounds discussed above, the Nevada Supreme Court erred in this case. That court rejected Riggins' claim without making any inquiry into whether the medication was necessary to serve any state interest. *Riggins*, 808 P.2d at 537-38. Moreover, the state trial court made no findings that the medication, in the concededly very high dose of 800 mg per day that was being given to

[16] The manner in which the State may establish its interests should be left, like other evidentiary matters, to the discretion of the trial judge. We see no basis for a rule that, always or even presumptively, requires the cessation of medication for a period to determine the need for the medication. Such a medical experiment carries risks to the defendant, the prison, and the State's judicial system; and psychiatric and other testimony often will be an adequate basis for the court's determination.

Riggins (*see* R.O.A. 431, 473, 504-05), was necessary to treat a mental illness consistent with proper institutional needs or to maintain Riggins' competence to stand trial. *See* R.O.A. 108 (denying termination of medication, without opinion), 495-505 (argument of counsel after hearing on motion to terminate medication; court taking motion under advisement). The administration of the medication cannot be found lawful without any such findings. And a remand is necessary because the evidentiary record is hardly so clear and one-sided on the issues that only one conclusion is possible.[17]

Thus, on the question of a *Harper*-type justification, the trial court gave no indication that it thought the State had any such justification. *See* R.O.A. 495-505. The whole issue of dangerousness or deterioration, in fact, was never explored below, because the State did not base its argument for involuntary medication on any claim of a *Harper* interest; the State argued only "that medication in this case is required in order to continue the defendant's competency." R.O.A. 497; *see id.* at 496-99 (prosecutor's closing argument at hearing on termination

[17] Not suprisingly, there are likewise no specific findings on what adverse effect, if any, the medication had on Riggins' demeanor before the jury, either while listening to others testify or while testifying himself. In our view, as explained above, no such effect need be demonstrated in a particular case before the State is required to justify the medication. *See* page 15, *supra*. If a demonstration of effects is needed, however, the issue should be left for remand, because the record seems sparse, and less than clear, on the issue. *See, e.g.*, R.O.A. 429 (Dr. Master: defendant closed eyes several times at hearing), 445 (Dr. Quass: no apparent effect), 503 (trial court referring to "the expert testimony that [Riggins] is sedated"), 505 (trial court: "there is some indication that it might have some adverse effects with this type of a dosage"), 753 (Dr. Jurasky discussing possible sedative effects of Mellaril), 834 (Dr. Master on same subject). Of course, the inquiry into adverse effects on demeanor may look much like the harmless error inquiry that the courts might undertake even if they examine the adequacy of the asserted state justifications first and find them wanting.

of medication); *id.* at 74-87 (State's brief on issue). On the other hand, one doctor testified that if Riggins stopped taking Mellaril, "he would be dangerous" and that "the Mellaril allows him to act in more or less a normal manner." R.O.A. 753 (Dr. Jurasky). But that apparently isolated testimony, which was offered by Riggins, did not specifically focus on whether he would deteriorate or be dangerous while confined. And the medication was originally prescribed, not for reasons of dangerousness, but simply because Riggins complained of hearing voices and was having trouble sleeping. R.O.A. 441-42 (Dr. Quass). The record, in short, can hardly compel a finding that the medication was necessary to serve the State's (unasserted) treatment and institutional interests.

On the question of maintaining competence, the record contains substantial evidence from the State's own witnesses suggesting that the medication, at least in the high dose of 800 mg per day, was *not* necessary to maintain Riggins' competence. Thus, Dr. Quass, the doctor who originally prescribed the medication after Riggins' arrest, answered "yes" when asked if it was his "opinion that [Riggins] would be competent to stand trial even without the administration of Mellaril." R.O.A. 443. Dr. Quass explained: "At the time [Riggins] was started on Mellaril I considered him to be competent. He was not grossly psychotic at any time." R.O.A. 443. Although there was a possibility that Riggins could become psychotic if his Mellaril were stopped, Dr. Quass added, he "would be surprised if that happened." R.O.A. 444. *See also* R.O.A. 449-50. Dr. O'Gorman, who saw Riggins in both 1982 and 1988, doubted that the high dose was necessary and testified that he "never saw [Riggins] as an incompetent person" at either time (R.O.A. 475) and that he did not know what would happen if the medication were discontinued (R.O.A. 476). Dr. Master, who saw Riggins only when he was medicated (R.O.A. 410), said that his "guess is that taking . . . [Riggins] off of

medication would have no noticeable effect," although "there is always the possibility" of an effect. R.O.A. 412. At trial, he added that he "would never prescribe Mellaril for Mr. Riggins as he is now." R.O.A. 836; *see* R.O.A. 837-38.

At a minimum, therefore, a remand is appropriate for the state courts to determine whether the medication was necessary to serve the State's asserted interests. On remand, the state courts should consider whether the necessary findings can be made on the present record. If not, the courts would have to decide whether any additional hearings could be meaningful years after the trial. The state courts should, in addition, be permitted to decide whether, even if the medication violated Riggins' due process rights, the error can legally and factually be deemed harmless. Of course, the harmless error inquiry might itself be meaningless without a new hearing into the effect of the medication on Riggins' demeanor at trial. All of these questions are sensibly left for remand.

CONCLUSION

The judgment of the Nevada Supreme Court should be vacated and the case remanded for further proceedings.

Respectfully submitted,

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